

Case Number:	CM14-0049490		
Date Assigned:	07/07/2014	Date of Injury:	09/19/2012
Decision Date:	09/15/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/17/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant was injured on 09/19/12. An EMG/NCV of the lower extremities is under review. He was injured when he fell from a roof and was diagnosed with cervical spine and lumbar spine injury and bilateral lower extremity radiculopathy. He has participated in PT and chiropractic. PT was not helpful. Chiropractic helped temporarily. He saw Dr. [REDACTED] on 02/14/14 for a QME and he stated that studies had been ordered and were denied. His pain ranged from 5-8/10 and was present daily. It radiated to the left hip and buttocks and went down both legs anteriorly and posteriorly. The low back pain also was associated with left flank pain, left inguinal pain, and burning in the left lower quadrant. He also had pain going from his low back to his rectum. He had feelings of depression and tiredness. He had bilateral paraspinal tenderness that was inconsistent. Range of motion of the lumbar spine was normal. Straight leg raises seated and supine were positive. There were inconsistent hypoesthesias in the bilateral lower extremities in a nonanatomic distribution. On 02/14/14, he saw Dr. [REDACTED] and complained of low back pain radiating to the lower extremities. He had 1+ reflexes of the Achilles tendon and positive bilateral straight leg raises. There was inconsistent hypoesthesia in the lower extremities. Motor evaluation was unremarkable. He has not had any lumbar MRIs or electrodiagnostic studies to date. Exam showed tenderness in the low back area. A request was made for EMG/NCS. On 03/12/14, he had ongoing pain in his low back. He had tenderness and spasm of the neck and low back. On 05/07/14, he saw Dr. [REDACTED] and PT was authorized. He was also going to see a general surgeon for rectal bleeding. He had tenderness and positive impingement about the shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Electromyography of the Lower Extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The history and documentation support the request to EMG only for the bilateral lower extremities. The claimant has persistent symptoms involving his low back and both legs that are not focal but have persisted despite a trial of chiropractic and PT and the passage of a significant amount of time. The MTUS state "unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." In this case, there are no specific focal findings on physical examination that support radiculopathy at a particular dermatomal level, but the claimant has chronic complaints with abnormalities of sensation that have not been explained. NCV are not typically necessary for the diagnosis of radiculopathy and EMG should be sufficient. There is no evidence of peripheral nerve dysfunction to support proceeding with NCV, in addition to EMG. The claimant had a significant fall and remains symptomatic and it appears that additional evaluation via EMG is reasonable and appropriate under these circumstances.

Nerve Conduction Velocity Studies of the Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The NCV is not medically necessary or indicated. The claimant has persistent symptoms involving his low back and both legs that are not focal but have persisted despite a trial of chiropractic and PT and the passage of a significant amount of time. The MTUS state "unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be

obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." In this case, there are no specific focal findings on physical examination that support radiculopathy at a particular dermatomal level, but the claimant has chronic complaints with abnormalities of sensation that have not been explained. NCV are not typically necessary for the diagnosis of radiculopathy and EMG should be sufficient. There is no evidence of peripheral nerve dysfunction to support proceeding with NCV.